A WHITE PAPER ON PRESCRIPTION DRUGS:

A Comprehensive Review of Problems That Face Washington State Residents and Recommendations for the Future

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III. THE SYSTEM

So, Just What Are Drugs?

Webster defines a drug as "***any substance used as a medicine or in manufacturing medicine for internal or external use***." But for this discussion we mean "prescription" drugs, those that are regulated in the manufacturing, issuance, or sale. Under our state law they fall into the following categories.

Controlled Substances are generally narcotics and can be addictive and harmful if used improperly. They require a prescription and must be dispensed by a pharmacist. There are five classes or schedules:

- **Schedule I** — drugs that have no currently accepted medical use in the United States including heroin, PCP, marijuana (notwithstanding Initiative 692). They are illegal and cannot be prescribed.

- **Schedule II** — drugs that have a medical use but also a high potential for abuse, including morphine, codeine, amphetamines. All prescriptions must be written and signed and are not refillable.

- **Schedule III** — drugs that have a medical use and have less potential for abuse than Schedule II, including combination products such as Tylenol with Codeine, Hydrocodone with acetaminophen (Vicodin), some weight-loss drugs.

- **Schedule IV** — drugs that have a medical use and have less potential for abuse than Schedule III, including Librium, Valium, and Darvon.

- **Schedule V** — drugs with small quantities of the above controlled substances mixed with other ingredients in such a way as to reduce the potential for abuse, including cough syrups containing codeine and certain anti-diarrheal preparations.

LEGEND DRUGS are all other pharmaceuticals that require a prescription but are not a controlled substance—less dangerous. They must be dispensed by pharmacists. The prescriptions may be refilled at whatever frequency designated by the prescriber, subject to certain limits for Scheduled Drugs, and to a maximum of one year for any Legend Drug in Washington state. The pharmacy decreases the number of remaining refills each time one is dispensed. When all of the refills have been exhausted, the pharmacy must contact the prescriber in order to obtain authority to continue dispensing the drug.

OVER-THE-COUNTER (OTC) OR NON-PRESCRIPTION DRUGS are drugs which may be purchased at pharmacies, grocery stores, vending machines, mini-marts, and any other vendor who has a shopkeeper license with the OTC endorsement from the State Department of Licensing. OTC drugs are seldom provided through health coverage, unless ordered by the provider.

Please note that products that are classified as herbal products, vitamins or nutritional supplements are NOT classified as drugs even though they may have drug-like effects. The apparent key is in how the manufacturer labels the product. As long as there is no claim that the product will treat or cure a disease or medical condition, it does not have to meet the same standards for safety or efficacy as drugs.

The following terms are often used in describing drugs:

- **Brand Name Drugs**, which are drugs still under patent to the manufacturer and only it can authorize the drug production.

- **Generic Drugs**, which are drugs that are no longer under patent and can be produced by other manufacturers. These drugs have the same active ingredients as the brand name version, although there may be minimal variations in the production process.

- **Therapeutic substitutions (or equivalents),** which are drugs that do not have the identical chemical structure as the brand name or generic, but have the same therapeutic effect.

WHO CAN PRESCRIBE DRUGS?

The authority to prescribe drugs is strictly controlled by state law and is the province of only 13 of the 54 regulated health professions. The scope of authority ranges from doctors of medicine and osteopathy, who have no restrictions, to optometrists, who are limited to eye drops.

When filling out a prescription or "script," the provider has the option of indicating to the pharmacist whether the drug must be issued as written or whether a substitution drug is permitted.

Figure 4: Who can prescribe drugs?

PRESCRIBING AUTHORITY	RESTRICTION
Physician (MD)	None
Osteopathic Physician and Surgeon (DO)	None
Dentist (DDS or DMD)	Any drug within the scope of practice
Podiatric Physician (DPM)	Any drug within the scope of practice
Certified Registered Nurse Anesthetist (CRNA)	Legend Drugs and Controlled Substance (II-IV) for anesthesia per hospital protocols
Advanced Registered Nurse Practitioner (ARNP)	Legend Drugs and Schedule V Controlled Substances within the scope of practice (Note that the Legislature authorized the addition of Schedules II, III and IV to ARNP's prescribing authority pursuant to rules to be developed by the state.
Medical Physician Assistant (PA)	Legend Drugs for a persons under a MD's care
Osteopathic Physician Assistant (PA)	Legend Drugs for a persons under a DO's care
Certified Physician Assistant (PA-C)	None, as long as the drug is for a person under a MD's care
Naturopathic Physician (ND)	Limited Legend Drugs as approved by the Secretary of Health
Optometrist (OD)	Topical Eye Drugs only
Veterinarian (DVM)	For animals only
Pharmacist (RPh)	Legend Drugs within the scope of practice and pursuant to protocols with other authorized prescribers

Who Regulates Drugs?

FDA

The U.S. Food and Drug Administration (FDA) has a major role in drug development. The Federal Food, Drug, and Cosmetic Act requires FDA to ensure that the new drugs developed by pharmaceutical companies are safe and effective. However, it does not give the agency responsibility to develop new drugs themselves. So, the FDA reviews test results submitted by drug developers. The purpose is to determine whether the drug is safe enough to test in humans and, if so—after all human testing is completed—to decide whether the drug can be sold to the public and approve what the label says about directions for use, side effects, warnings, and the like.

NIH

The National Institutes of Health (NIH) performs and funds a great deal of pharmaceutical research and development. In doing so, it imposes extensive standards on the conduct of such research. One important standard is what is called “Human Subject Review,” which provides privacy and other protections for persons participating in treatment studies, called “clinical trials.”

State Board of Pharmacy

This board, which was independent for years, is now part of the State Department of Health. The Board licenses about 12,000 pharmacists and support staff, and around 2,200 pharmacies, wholesalers, and health care entities. It also is the disciplinary body for pharmacists practicing in violation of the law.

Office of Insurance Commissioner

Here, authority is limited to the review of what drug benefits are included in insurance coverage. The office has no authority over direct purchase of drugs or what is included in Employee Retirement Income Security Act (ERISA) or self-funded plans. Recently, the Washington State Legislature adopted laws that established a Patient’s Bill of Rights and a mandated drug benefit. The Office is considering rules to clarify those provisions.

What Pharmacists Do:

Pharmacists are required to: Interpret prescription orders; compound, dispense, label, administer, and distribute drugs and devices; monitor drug therapy and use; initiate or modify drug therapy in accordance with written guidelines or protocols previously established and approved by a practitioner authorized to prescribe drugs; participate in drug utilization reviews and drug product selection; the proper and safe storing and distributing of drugs and devices and maintenance of proper records thereof; provide information on legend drugs which may include, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices.

Of particular note is the authority to initiate or modify drug therapy in accordance with written guidelines or protocols established by another practioner is authorized to prescribe drugs. As a result of this change, over 600 pharmacists have submitted protocols to the Board of Pharmacy for review. These protocols include giving the pharmacists authority to provide pain management for hospice patients, initiate certain therapies in hospital settings, and adjust dosages of drugs based upon the response of the patient to the therapy. Over the past three years two areas of practice have increased significantly using protocols. Over 70,000 immunizations per year, particularly influenza vaccine and pneumococcal vaccine, have been administered in pharmacies. In addition, over 150 pharmacies have provided emergency contraception services to patients using conventional birth control pills in a different dosage regimen. According to studies, over 60 percent of the patients accessed these services from pharmacies during evening or weekend hours when access to physicians, family planning or other services was not available.

The role of the pharmacist has changed significantly over recent years. Much is due to the nature of drug manufacturing—no more mortar and pestle—but equally significant is the way drugs are purchased and dispensed. Larger purchasers and managed care organizations have sought cost efficiencies by the increased use of mail order pharmacies. In many cases this eliminates the pharmacist as educator and patient counselor. This is troubling especially for medication-intensive chronic illnesses such as diabetes. Even in cases where there is face-to-face contact, pharmacists are seldom reimbursed for this service. Further, pharmacists have complained that the intense workload requirements in many of the mega-pharmacies do not permit adequate time for patient consultation.

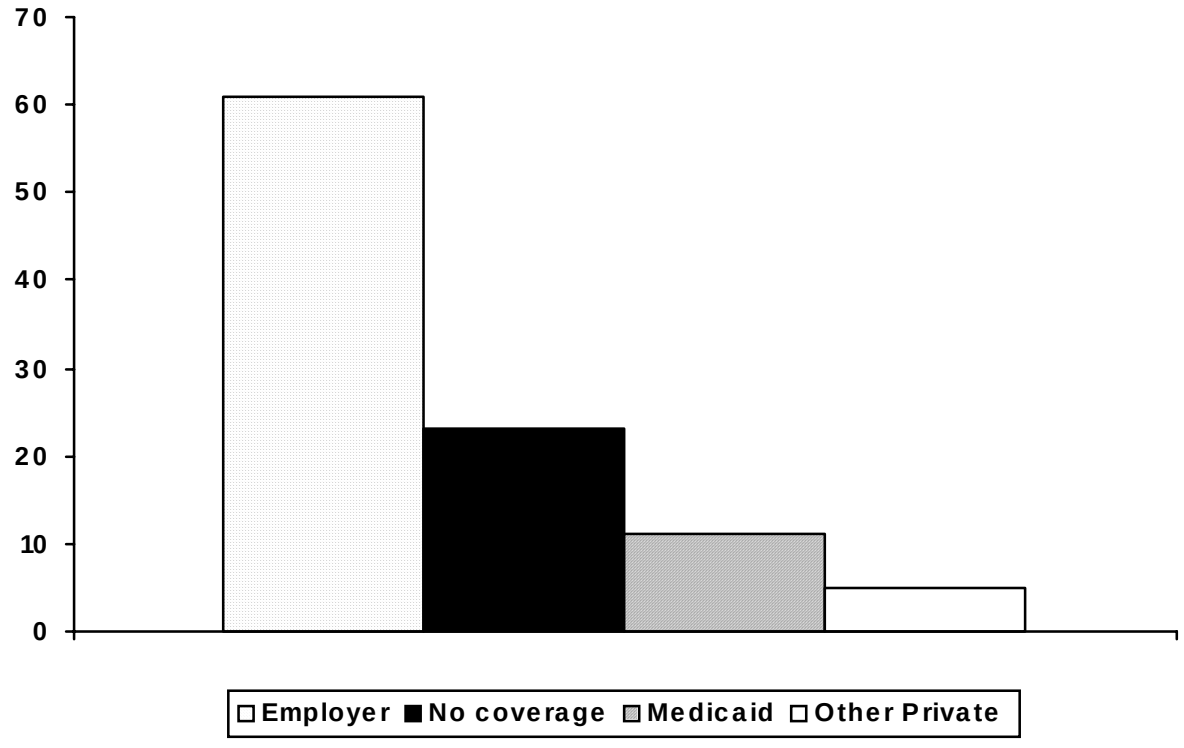
The current system also hinders the procedure of compounding of medicine. This process requires the pharmacist to modify the already prepared dosages and make them into a different dose, such as drugs for children, when the bonding agent must be changed due to a patient's allergies, or when synthetics can't be used and there is no actual formula prepared of the natural chemical. The compounding is time consuming and therefore expensive. The pharmacists can only bill for the major ingredient in the medication being compounded. Since they do not get reimbursed for these services, many pharmacies no longer compound.

Sources of Drug Coverage:

Non-Medicare Population

The majority of the non-Medicare population receives health care through employer-sponsored plans. Most employer-sponsored health plans offer some form of medication coverage. However, almost one quarter of non-Medicare beneficiaries do not have any form of prescription drug coverage.

Figure 5: Breakdown of drug coverage in U.S.



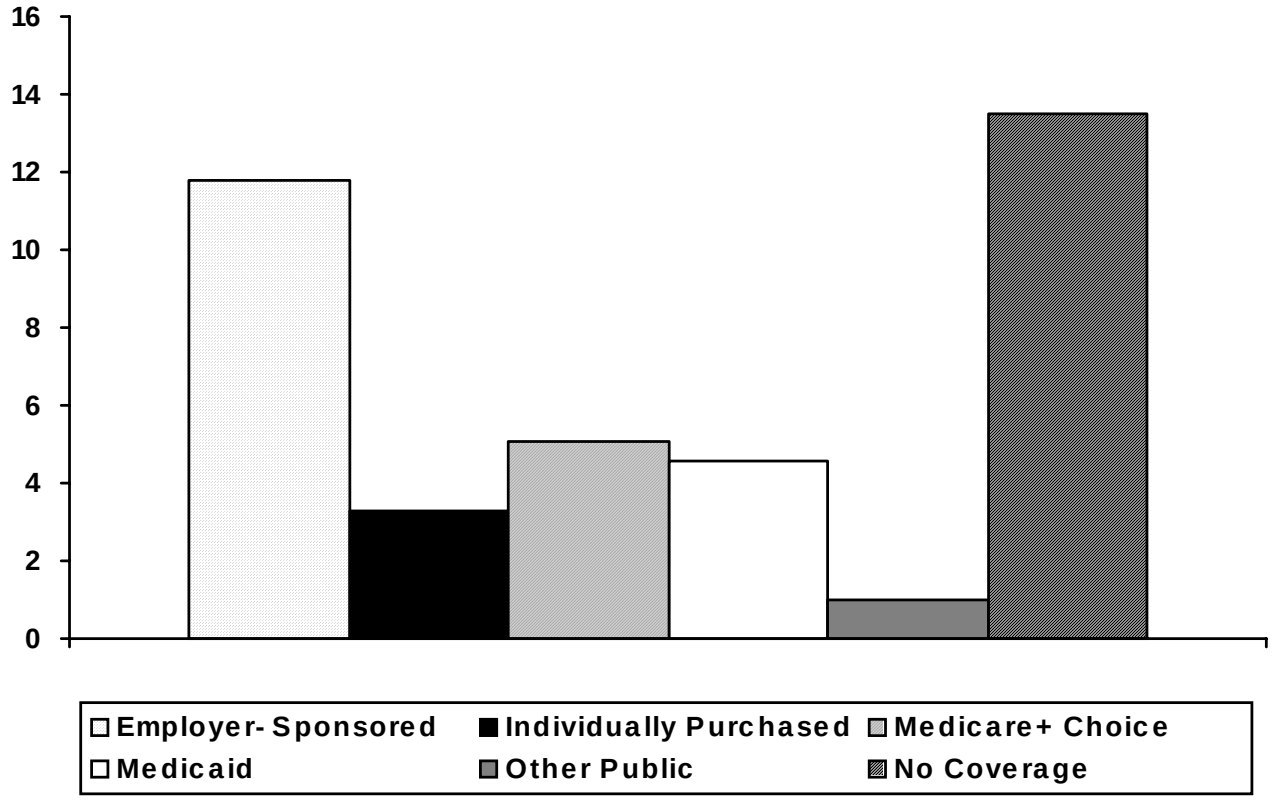
Source: Center for Cost and Financing Studies, AHRQ

MEDICARE POPULATION

Of Medicare beneficiaries, 65 percent (or 25.6 million) have some form of prescription drug coverage. Almost 60 percent of this coverage comes from private sources—either employers or individuals.

The remaining 35 percent of Medicare beneficiaries (13.5 million beneficiaries) do not have a drug benefit in their supplemental insurance package.

Figure 6: Breakdown of drug coverage among U.S. seniors



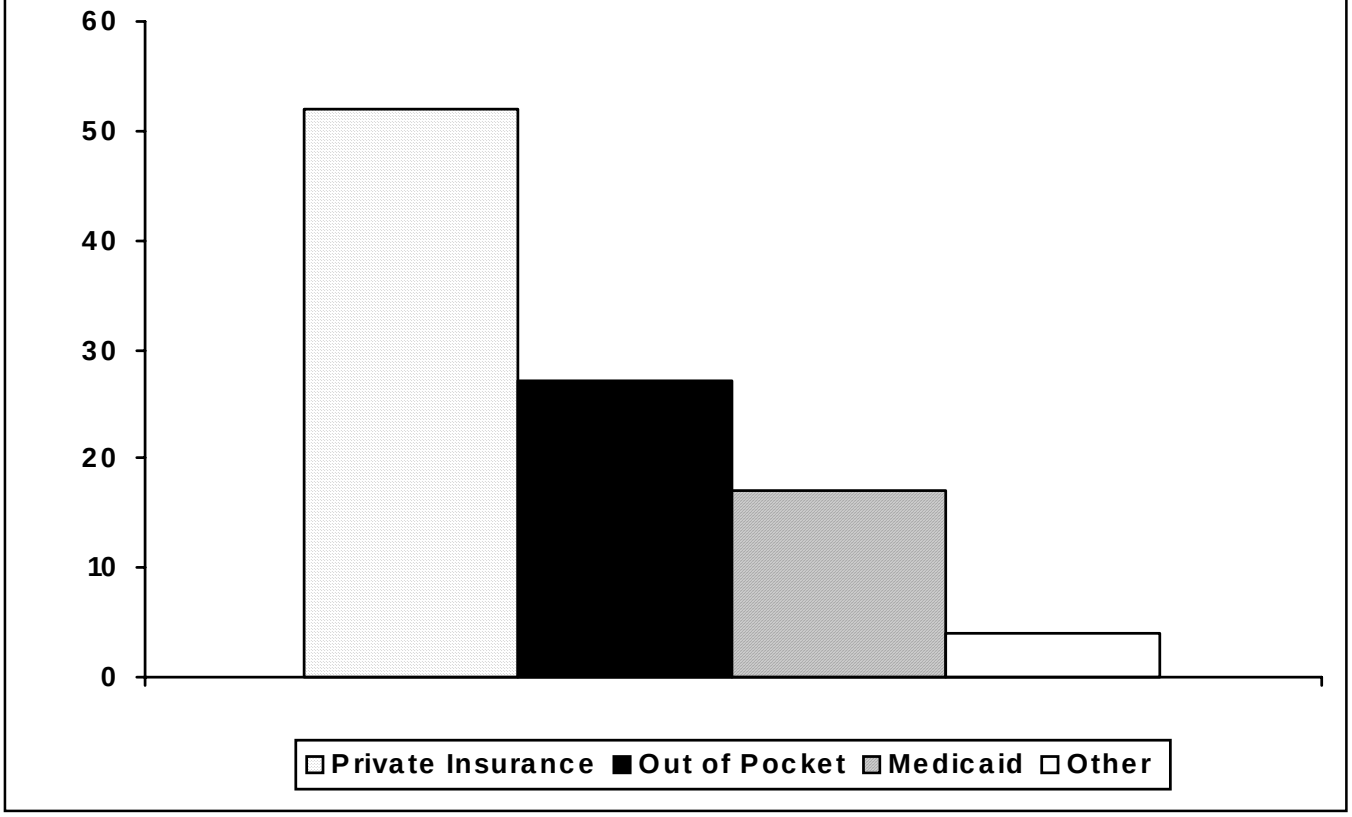
Note: Excludes beneficiaries who reside in institutions for the entire year. Other Public refers to beneficiaries who receive coverage through Department of Veterans' Affairs, Department of Defense, and state pharmaceutical assistance programs.

SOURCE: AARP PPI analysis using Medicare Benefits Simulation Model, 1999

Purchasers of Drugs

Private third-party insurers and consumers, who together pay for about 80 percent of all prescription drug costs, have primarily covered the cost of prescription drugs. Between 1965 and 1998, spending on drugs from every major payment source increased. However, expenditures by private insurance and Medicaid increased at the highest rate.

Figure 7: Drug spending by health plans and other payers



Prescription drug spending by health plans and employers grew 123 percent, from $17.9 billion to $39.9 billion between 1992 and 1997. Consumer out-of-pocket spending increased 13 percent, from $20.4 billion to $23 billion.

Drug Purchasing Mechanisms:

Other than individuals, most purchasers will be involved with a Pharmacy Benefits Manager (PBM), a Formulary, and a Pharmacy and Therapeutical (P&T) Committee.

PBMs

Pharmacy benefit management companies (PBMs) began appearing in the 1990s as a way to control drug costs. They provide claims processing, pharmacy network, and offer pharmacy benefit plan design to insurers and employers. They also create drug formularies, treatment guidelines, perform prior authorization for drugs, and encourage generic substitution. PBMs currently manage an estimated 71 percent of the volume of prescription drugs dispensed through retail pharmacies that are covered by private third-party payers. The PBM industry is concentrated. The top three PBMs—Merck-Medco Managed Care, PCS Health Systems, and Express Scripts—together manage approximately 45 percent of all such prescriptions. Several of the large PBMs are owned by drug companies, and federal law requires a "fire wall" between the PMB and the parent firm. However, analysts have raised the question of conflicts of interests. The Clinton Administration's proposal for a Medicare Part D benefit is a prominent example of a PBM-focused approach.

Formularies

A formulary is a listing of medications available to a prescribing health provider. A formulary's clinical role is to optimize drug use and reduce adverse effects. They are also used to control drug costs by limiting a provider's choice of medications. If a formulary is open, it generally means that that all drugs are available to the provider and patient. If it's a closed formulary, it means there is a set list of drugs that are available. The extent to which formularies reduce the overall cost of health care is still debated.

Pharmacy and Therapeutics (P&T) Committees

All insurance companies and most large purchasers have some form of P&T Committee. These committees usually consist of physicians, pharmacists and other affected parties (for example, nurse practitioners) and perform the initial evaluation of new medications for inclusion or exclusion on drug formularies. Often they have a PBM to assist them.

IV. BUYING DRUGS FROM OTHER COUNTRIES

In recent months many people, mostly seniors, have gone to Canada to purchase their drugs. A single bus trip from Seattle with 29 seniors aboard in May saved the passengers nearly $13,000 in the cost of their prescriptions. Some seniors cut their drug bills by more than half or even further. And although it seems to be a sad commentary on our own health care system that one must leave the country to get a good buy, these purchases are perfectly legal.

Some Precautions:

Washington residents who travel to Canada for this purpose should be aware of the following:

- You must travel in person. You cannot legally carry someone else's prescription across the border and have it filled.
- You must arrange for an interview with a Canadian physician in order to obtain a Canadian prescription for the drugs you need. This interview, which will cost you between $20 and $40, may include a physical examination. Those who have traveled across the border recommend setting up this appointment before you leave home.
- You should check beforehand with the Canadian pharmacy to confirm the drug's price and its availability. Not all U.S. drugs are sold in Canada. Nor are all drugs in stock all the time.
- Make sure your U.S. prescription is written for the longest period that your doctor feels is realistic — certainly three months and preferably six months or longer. Your regular pharmacist also may be able to advise you on the possibility of obtaining a longer prescription.
- It is legal to carry prescription drugs across the international border as long as you have the authorized prescription with you. Certain narcotics may only be carried across in a one-month or two-month supply. The Canadian pharmacy and physician should be aware of these restrictions.

Are Prices Really Lower Elsewhere?

Most price comparison studies have been small and limited to specific medications, dosage forms, or packages. None is conclusive. A recent study included generics and all medication sizes. It also weighted prices by volume of purchases. It found U.S. drug prices to be lower than Canada (by 3%), 27% lower than Germany, but 24% higher than the UK. Much of this debate depends on which price-index is selected, the volume of prescribing, and how the comparisons are made. Indications are that overall differences do not seem to be as great as suggested by early studies.[8]

Regardless of actual prices, the following are often cited as the major differences in U.S. comparisons with Canada and Mexico.

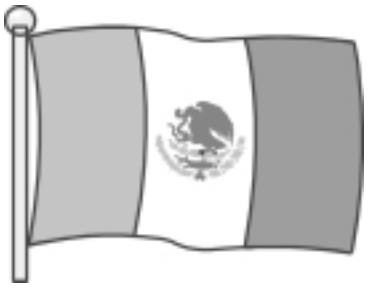
CANADA

There is less exposure to product liability in Canada than in the United States.

Canada's federal government controls the prices of new products, and post-launch prices may not rise faster than the consumer price index.

Further, some Canadian provincial governments also impose controls, such as British Columbia's reference price system.

Until recently, Canada's price controls were backed by a threat of compulsory licensing; that is, if the manufacturer of a patented drug did not accept the government's price, the government could force the manufacturer to license the product to a manufacturer who would produce a generic version. Although compulsory licensing was terminated before ratification of the North American Free Trade Agreement, prices of products that were launched under the compulsory licensing regime may still be affected by its tendency to suppress prices.



MEXICO

Mexico's per capita spending on health care was one-tenth of per capita spending in the U.S. and Mexico's per capita outlay for medicines about one-third of ours.

The Mexican government regulates drug prices.

Mexico did not enact patent protection for pharmaceuticals until 1991, and that law did not apply retroactively to products already on the market nor did it protect products then under development

Many drugs that require a prescription in the United States and Canada are available without a prescription in Mexican pharmacies.

V. NATIONAL REFORM ACTIVITIES

Although there has been no congressional action this year regarding Medicare and drug access, there is still some chance of legislation. The following are summaries of the most prominent proposals.

- **Clinton:** President Clinton's proposal would establish a voluntary Medicare Part D prescription drug benefit, similar to Part B, which would be available beginning in 2003 to all beneficiaries. HHS would contract with one private entity in an area to manage the benefit. Beneficiaries would pay a premium set to cover 50 percent of the costs of the new drug benefit, with the benefit being phased in to cover at full implementation 50 percent of the beneficiary's annual drug costs up to $5,000 in spending. Medicare would pay $2,500 of that total. Medicaid would cover the drug premiums and drug cost-sharing for beneficiaries with incomes below 135 percent of poverty. Medicaid would partially subsidize the drug premiums of those with incomes between 135 and 150 percent of poverty. Employer-sponsored retiree health plans could receive subsidies if they provided equal or better drug coverage. The President's plan is projected to cost $80 billion.

- **House:** The House passed a GOP bill (HR 4680) on June 28 that uses private insurance companies as the vehicle to begin prescription drug coverage for seniors over 65. The Republican bill provides taxpayer subsidies to encourage insurers to offer policies with premiums estimated as low as $35 per month. Participation is voluntary, and seniors taking part can choose between at least two plans. All plans begin with a $250 deductible. A new agency, the Medicare Benefits Administration, is to run the program. Sponsors believe the new plans' volume buying power will lower drug costs. The legislation covers 100 percent of drug and premium costs for couples with incomes up to $15,200 and singles with incomes up to $11,300. For all participants, it covers at least half of drug costs up to $2,100 annually and 100 percent of out-of-pocket costs over $6,000. Details on coverage of costs between $2,100 and $6,000, if any, will vary according to the company and policy. The bill is projected to cost $39 billion over five years. President Clinton has promised to veto the bill.

- **Senate:** In response to the House bill, Sen. William Roth, R-Del., has proposed a bill calling for drug coverage within an "enhanced option" in Medicare that includes broader coverage but higher premiums. Seniors could pay up to a $500 deductible, and then Medicare would pay up to 50% of prescription drug costs. For those with high annual medication expenses, the government would pay up to 80% of costs. For low-income seniors, Medicare would subsidize the premiums and deductibles. This proposal currently is receiving bipartisan praise. No costs have yet been calculated for the Roth plan.

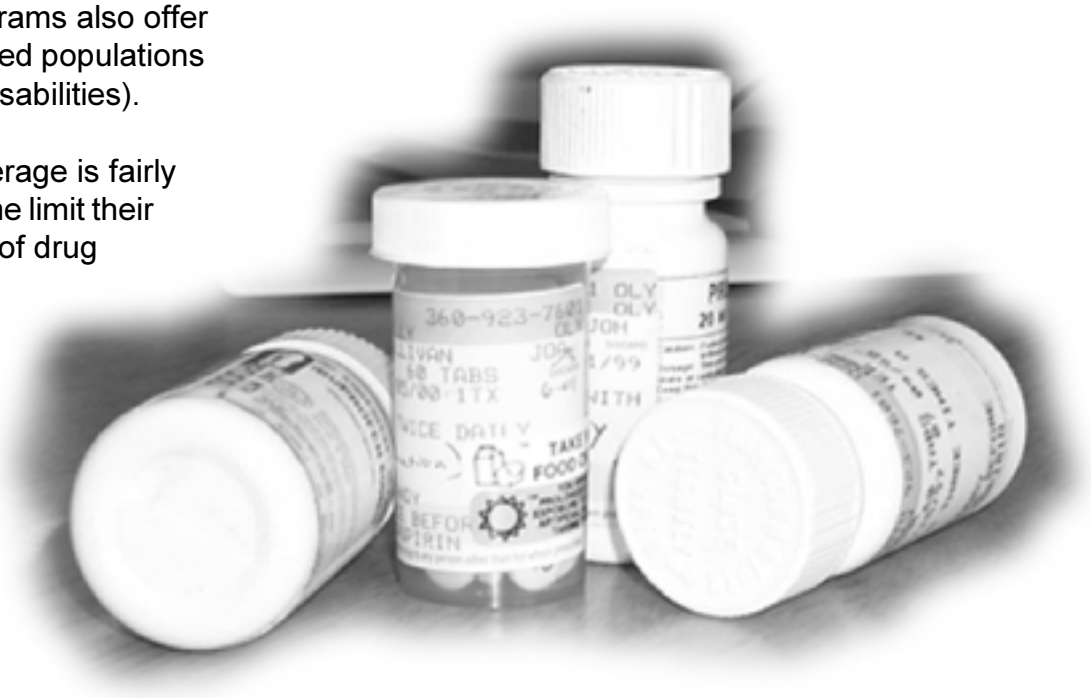
- **Breaux/Frist (S.1895):** A “competitive premium system” would be established, run by a Medicare Board. Beneficiaries would elect to enroll in a Medicare plan, either privately sponsored or sponsored by HCFA. All plans must include at *least* current Medicare benefits. All beneficiaries would have access to outpatient prescription drug and stop-loss coverage through enrollment in a high option plan. Plans would set premiums. The government would contribute 88 percent of the national weighted average premium (NWAP); beneficiaries would pay the difference. There would no longer be a Part B premium. In addition, the government would subsidize 25 percent of the actuarial value of the prescription drug benefit, with higher subsidies for lower income beneficiaries. The drug benefit would have an actuarial value of $800 in the year 2003, adjusted annually for increases in drug costs. Benefit design could vary. Only beneficiaries enrolling in the HCFA-sponsored standard plan (i.e., plan with Medicare benefits only) could buy or renew Medigap policies.

VI. STATE REFORM ACTIVITES

In recent legislative sessions more than half of the states have struggled with the problem of rising drugs costs and declining drug benefits.[9] Activities fall into two categories: Pharmacy assistance programs and some form of discounts, rebates or price controls.

Pharmacy Assistance Programs:

Until 1999 pharmacy assistance programs were in operation in 16 states. Now that number has grown to 23 with, apparently, others to follow. Most of the programs are targeted toward persons age 65 and over, although about half of those programs also offer coverage to other selected populations (such as persons with disabilities).



In most programs, coverage is fairly comprehensive, but some limit their coverage to a small set of drug products or to individuals with one of several specified medical conditions. Each program requires some cost-sharing by enrollees—typically a co-payment of a few dollars per prescription, although in some programs the co-payment can be substantially higher. Most programs do not require enrollees to pay a deductible before receiving benefits.

Funding sources for state pharmacy assistance programs include general revenues, state lottery proceeds (Pennsylvania), and casino fund revenues (New Jersey). Recent entries include California, Delaware, Maine, Nevada, and North Carolina in 1999 and Indiana, Kansas, Florida, and South Carolina in 2000.

Discounts, Rebates, Price Controls And Bulk Purchasing:

***1999 Laws*:** California enacted SB 393, which requires pharmacies that serve Medicaid beneficiaries to provide a similar discount price to Medicare beneficiaries. Maine enacted the "Maine Resident Low-Cost Prescription Drug Program," which provides discounts to residents who lack third-party prescription drug coverage. The Massachusetts FY2000 budget includes authorization for a state bulk purchasing program for pharmaceuticals for an eligible population estimated at up to 1.6 million. Texas enacted a program for voluntary drug rebates, to be passed on to individuals in the state's kidney and children's program.

***2000 Laws*:** On May 11, Maine became the first state to enact a form of price controls when the Governor signed S.1026, now Chapter 786 of 2000. The final amended law also creates a discounted price for enrollees without pharmaceutical insurance coverage (see details below). A Florida law, signed June 8, creates a discount prescription drug-pricing program for Medicare enrollees, based on existing Medicaid rates. A Minnesota law, signed March 31, regulates and restricts commercial pharmacy discount card plans. A Vermont FY2001 budget section authorizes a Medicaid waiver to permit including elders over 175 percent of poverty and others under 300 percent of poverty to receive a subsidy equal to "the average rebate paid to the Medicaid program by pharmaceutical manufacturers."
Other bills have been filed in Arizona, California, Colorado, Connecticut, Florida, Illinois, Maryland, Minnesota, Missouri, New Hampshire, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Washington and Wisconsin.

Description of Policy for Prescription Drugs	States with Bills or Laws, 1999-2000
Medicare elders/disabled eligible for discount prices based on Medicaid rates	AZ, CA, CT, CO, FL, MA, MD, ME, MN, MO, RI, VT, WA, WI
Seniors eligible for discount prices based on "Federal Supply Schedule"	AZ, IL, PA, VT
Broader public use of Federal Health Centers (FQHCs sell prescription drugs at discounts similar to Medicaid rebate rates)	CT, RI, VT
State bulk purchasing to achieve greater price discounts for all eligible groups	CA, FL, GA, MA, ME, NY, OR, RI
Price controls or state maximum prices	ME

VII. CONCLUSIONS

The role drugs play in our lives is substantial and it will probably expand in the foreseeable future. Part of this is good because it appears to have improved the quality and length of our lives.

This success and the growth of drug coverage through insurance has created a high expectation that drugs should be our main source of treatment. Promising approaches that do not rely on drugs, such as, the primary intervention and demand and disease management, are not fully integrated into the medical care mainstream.

However, this success has increased the cost of drugs and overall health care to where it has significantly reduced the availability of affordable drug benefits in health insurance coverage.

The lack of a Medicare drug benefit is a major factor, but drug sponsorship is declining also in the Non-Medicare sector where a quarter of all persons have no drug coverage. Further, employers are seeking ways to reduce employee-benefit costs by reducing drug sponsorship. This also has an added impact on seniors who rely on their private retiree benefits to supplement Medicare.

Drug manufacturers are for-profit entities and have been extremely successful. Any effort to reduce overall profitability must take into account the impact to future drug development.

There are several promising proposals at federal and state levels, but the potential for passage is unclear.

Although short-term strategies may diminish the crisis temporarily, only a fundamental re-thinking of our drug policy will produce long lasting changes. This will require the involvement and sacrifice of all sectors of society: policy makers, insurers, providers, manufacturer, and citizens.

APPENDIX A: COMMISSIONER'S RECOMMENDATIONS

POLICY PRINCIPLES:

As policy-makers grapple with solutions to the drug cost and coverage problem, it is important to set forth a number of principles on which our efforts should be based.

THE SOLUTIONS SHOULD:

Focus on improving citizens' health status

Be integrated into broader health care strategies

Be based on medical efficacy and efficiency

Prohibit discrimination based on sex, health need, and method of treatment

Encourage the appropriate responsibility among individuals, providers, insurers, purchasers, manufacturers, and government

Not unduly hinder the drug industry from developing appropriate medications and treatments in the future

Enhance consumers' knowledge of the system and facilitate them in making the appropriate treatment decisions

Permit health providers to fully participate in their patients' care within their scope of practice consistent with medical efficacy

Provide adequate public resources for those unable to purchase needed drugs

FEDERAL LEVEL ACTION:

IN LIGHT OF THE ABOVE PRINCIPLES, THE PRESIDENT AND CONGRESS SHOULD CONSIDER ONE OR SEVERAL OF THE FOLLOWING:

Create a Medicare drug benefit

Require PBMs for Medicare beneficiaries

Provide matching funds for state pharmacy assistance programs

Require manufacturers to participate in a Medicare drug-rebating program similar to that of Medicaid

Permit interstate Medicaid/Medicare purchasing cooperatives

Direct federal health agencies to develop "no-nonsense" strategies to encourage appropriate drug use

Develop guidelines for pricing strategies that will assist state bulk-purchase systems

Enhance the safety of drug use and reduce medical errors

State Level Action:

Further, the Governor and the Legislature should consider the following:

Establishing a comprehensive pharmacy management task force, the purpose of which is to recommend policies that would reduce overall drug costs by strengthening the states purchasing power and encourage the appropriate use of drugs through proper demand and disease management

Creating a pharmacy assistance program

Creating a voluntary drug manufacturer rebate program for Medicare/disabled persons

Requiring a mandatory Medicare/disabled person discount from pharmacists that do business with the state

Permitting Medicare recipients and other persons who have problems obtaining medication to purchase drugs through state programs

Consider entering into a compact with other states to purchase drugs for state programs and low-income persons

Increasing the income eligibility standards for dual-eligible Medicare/Medicaid beneficiaries

Eliminating discrimination in drug coverage by passing legislation like the contraceptive drug coverage and mental health parity bills

Establishing a comprehensive drug education program

The Insurance Commissioner will do the following:

Require insurance companies to fully disclose drug benefits

Prohibit sex or other group discrimination in formulary design

Establish a role for consumers in drug benefit design

Establish parity in drug dispensing between local pharmacy and mail order organizations

Enhance the role of pharmacists and other under-utilized health providers in patient education and disease management

Guarantee that health plan drug benefits offer the full range of drugs, including generic, formulary, and off-formulary drugs, consistent with appropriate enrollee cost participation.

APPENDIX B: REFERENCES

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